DEPARTMENT OF MEDICAID SERVICES
BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

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WEDNESDAY, JANUARY 22, 2025
2:00 P.M.

Stefanie Sweet, CVR, RCP-M
Certified Verbatim Reporter

A P P E A R A N C E S

TAC Members:

Sheila Schuster, Chair
Steve Shannon
TJ Litafik
Valerie Mudd
Tara Hyde
Misty Agne
Mary Hass

DR. SCHUSTER: Hello. Hi, Erin.

MS. BICKERS: Good afternoon, Dr. Schuster. You beat me to it. It's not quite 2 o'clock and we are clearing out the waiting room so I will give it just a moment. How are you?

DR. SCHUSTER: I'm fine, thank you. I'm glad to be back even though it's cold and I left 63 degrees out in Arizona, so it is a bit of a shock to the system.

MS. BICKERS: I bet.

DR. SCHUSTER: And I see Valerie is on. Do we have some of our voting members? Have you seen them?

MS. BICKERS: Steve and Mary are on.

DR. SCHUSTER: Steve and Mary are on, you said?

MS. BICKERS: Yes, ma'am.

DR. SCHUSTER: Okay.

MS. BICKERS: And Val is also on, but you saw her. As soon as the waiting room clears, it fills right back up.

I did want to make a request.

If Jiordan might be able to move up a little bit on the agenda, she has to drop for another call.

DR. SCHUSTER: And is that on the unwinding?

MS. BICKERS: Yes, I believe that is the updates on that.

MS. GRIFFIN: Yes. That would be the unwinding status and recertification update, if that is okay with everybody.

DR. SCHUSTER: Yes. We kind of moved things around a little bit on the agenda from when we first scheduled until now.

Yeah. Why don't we move you up, Jiordan, after we hear from Victoria Smith and from Myers & Stauffer. Or, would it be better to move you up further than that?

MS. GRIFFIN: I can wait until after we discuss with them. That's fine.

DR. SCHUSTER: Okay. Thank you. And we will see what our timing looks like. I don't know how long those

presentations are going to be, but we can move you up further if need be.

MS. BICKERS: TJ is coming in and joining us.

DR. SCHUSTER: Thank you.

MS. BICKERS: The waiting room is clear so I will turn it over to you, Dr. Schuster.

DR. SCHUSTER: Okay. Thank you Erin, and good afternoon on this very cold January 22nd. I appreciate your flexibility and our need to reschedule the meeting from the 9th.

So welcome to the Behavioral Health TAC meeting, formally scheduled for January 9th, but now being held on January 22nd.

Val, do you want to greet folks as one of our voting members?

MS. MUDD: Yes. I am Valerie Mudd and I represent folks living with a mental illness, like myself.

DR. SCHUSTER: Thank you, Val.

And Mary?

MS. HASS: I am Mary Hass,

representing individuals with brain injuries.

DR. SCHUSTER: Thank you very much.

And Steve?

MR. SHANNON: Steve Shannon with the KARP Association and Health Centers.

DR. SCHUSTER: Right.

And TJ?

MR. LITAFIK: TJ Litafik, NAMI Kentucky.

DR. SCHUSTER: Great. Thank you.

Is Misty Agne on?

MS. BICKERS: I don't see her on yet.

DR. SCHUSTER: Okay. And Tara Hyde?

MS. BICKERS: I don't see her either.

DR. SCHUSTER: Well, we will go on. We have a quorum so we are constituted to do business, as they say.

Let me get a motion from one of our voting members to approve the

minutes -- actually the court reporting of the November 14th Behavioral Health TAC meeting, please.

MS. HASS: I will make a motion for the November 14th.

DR. SCHUSTER: Thank you.

And a second?

MS. MUDD: I will second. Val.

DR. SCHUSTER: Val? Okay.

Any additions, corrections, omissions, revisions? All right. All those in favor of approving the minutes, then, signify by saying, "aye."

TAC MEMBERS: Aye.

DR. SCHUSTER: Any opposed? And abstentions? Great.

We just got the response from DMS to the Behavioral Health TAC recommendations that were made back in November and it is a lengthy reply. Hopefully you all got it on the email.

Erin sent it to the voting members and then I sent it also to the people on my email list that attend these meetings.

I don't know how much time -- I have not had time, quite frankly, to go through and look at this. It is quite lengthy. I don't know that we have ever had -- we had several recommendations, but this is much more detailed.

MR. MARTIN: Sheila, this is Barry.

DR. SCHUSTER: Yes.

MR. MARTIN: I reviewed it and, I mean, it pretty much validates some of our concerns, but it doesn't really put a lot of, I guess, direct directions of how are we going to accomplish this.

I think Medicaid is saying it is under the purview of doing what we are asking, but how do we get that to be a little more -- have a little more bite to it?

MR. SHANNON: Sheila, this is Steve Shannon.

I agree with Barry. There are some affirmations of valid point or concern, but it really doesn't seem like -- I don't know we go back with a

recommendation. If we review it in detail, come back again. The audit questions are responded to, I just don't know if we get -- or what happens next.

Does that seem fair, Barry?

MR. MARTIN: Yes. I think -- same thing.

MS. HASS: This is Mary Hass.

I didn't review it. I did a cursory review and I would have to go with Barry and Steve and say I just don't think there was a whole lot of meat into it.

They were answered, but I think we are going to have to go more in depth to say exactly, you know, what it is, but again, I didn't give it a full review so I just want to give that, but on a cursory review, I just didn't think there was much there.

DR. SCHUSTER: And Michelle has in the chat, "It seems like the responses were directed to prepayment reviews and not the other audit."

So obviously we will still have a lot of questions about audits.

The parallel thing that has come up since we met up in November and since we set this agenda, as some of you know, Secretary Friedlander sent out a letter asking for input on -- I forget what the exact words were.

MR. SHANNON: Starting prior auth.

DR. SCHUSTER: Yes. Starting prior auth. And I think that this BH TAC have long felt that the audience were in large measure in response to not having prior auths.

What I would like to do is make sure that everybody has these. Let's review them in detail between now and the next meeting.

Let's also see what is happening on the parallel track with the full discussion about resuming prior auths, because I think that will have an impact of the number and extent of the audits, or at least that is the feeling that I've had over the last three BH TAC meetings.

Does that make sense, Steve and

Mary?

MR. SHANNON: Yes. It's a lot of information to really develop a strategy around in three hours.

DR. SCHUSTER: Yes.

MR. SHANNON: I appreciate the response, but I just think we need to spend more time understanding it and discuss it more.

MS. HASS: Yeah, I need more time.

DR. SCHUSTER: Bart?

MR. BALDWIN: Just a quick comment on the response. It lays out several of the requirements that are in place on the timelines of the audits and I think a core question from this group is: What happens when those aren't followed?

So I think that was kind of my review of it is there are lots of things that are already requirements in the contract with the MCOs that Medicaid requires, and I think our concern is great. We appreciate those, but when they are not followed, then what?

And I think that is the lens that we need to look at and what is the corresponding accountability when those timelines are not followed, because our experience for hearing from the providers is that oftentimes they're not -- the requirements are not followed, but then what is the recourse?

DR. SCHUSTER: Yes. That is a good point, Bart. And I will make note of that. I appreciate that.

MR. BALDWIN: Thank you.

MR. MARTIN: Sheila, I'm glad that they did respond and they did validate some of this stuff, so it does give us some leverage when we want to go to the MCOs and DMS and say that we are being unjustly done.

DR. SCHUSTER: Yes. So it has been worth all of those sometimes lengthy and heated discussions that we've had in the BH TAC meetings, I guess, starting in July -- July, September, November.

So I appreciate that, Barry, as well. That is the direction that we will

take at this point.

Thank you all, and I will get back and send an email back to Commissioner Lee. She is on vacation right now, but I will send her an email and tell her that we appreciate the length and the input and we will be getting back to them for next steps.

MS. MUDD: Yes. I think that we got the vibe from a few of the MCOs saying that we are going to do these audits, but you all didn't want to do the prior auths. So this is what you get. That is what it felt like to me.

DR. SCHUSTER: That certainly was the tone from time to time in those discussions, Val. I appreciate that.

I have a grid that I will send out of the 2025 BH TAC and MAC meetings, and I appreciate the change of this one, but the BH TAC meetings will be on the second Thursday of each month in that two to four time frame.

We used to shift when they were in session -- or not in session -- but the

two to four time frame works for our voting members.

So the MAC meeting -- that's March 14th, May 8th, July 10th, September 11th, and November 13th.

MS. MUDD: Is it March 13th or 14th? Because you've got on the schedule the 13th.

MR. SHANNON: It would be the 13th.

MS. MUDD: I wanted to double check that.

DR. SCHUSTER: Yeah. We don't want to do Friday. Thank you. I will correct that before I send it out.

The MAC meetings are on the fourth Thursday except in November because of Thanksgiving, so January 23rd, March 27th, May 22nd, July 24th, September 25th, and then November 20th. And again, 9:30 a.m. until 12:30 p.m.

The MAC will be meeting tomorrow morning at 9:30 and I will send that corrected version out, and Erin will get it out to you all, but I will send it to

my email list.

Next on the agenda -- is Victoria with us? Victoria Smith?

DR. HOFFMAN: Dr. Schuster, she is out today. But I wanted to discuss that just a second. And I know Commissioner Lee is not available and I don't believe Veronica is on, so I will do my best to try to explain about the rate study.

I am not sure if you are aware, but there is a much larger request for a full rate study initiative that is required and has to be completed for LRC, and so they are going to embed phase II, it's multistate work, into that work for the LRC.

So currently right now, Medicaid and others are being tasked to get to gather data and information to submit over to the LRC identified staff.

I know that is not what you wanted to hear, but that is where we are. It is going to be embedded into a much larger study that is going to be completed

by LRC staff.

DR. SCHUSTER: And that request is part of what was in the budget bill, as I recall?

DR. HOFFMAN: Yes.

DR. SCHUSTER: They put some money aside and created an office over there.

DR. HOFFMAN: We have currently -- they have requested a lot of reports for us and Medicaid has been working on getting those reports turned around quickly.

It sounded to me that the initiative was to go fairly quickly though. It's not going to be one of those that lags on for years and years. I think they've directed staff to complete their tasks fairly soon. I don't have a timeline for you. I'm sorry.

DR. SCHUSTER: Okay. We still did not get, from Victoria, the final piece of phase I, and that should not be --

DR. HOFFMAN: The final of phase

I?

DR. SCHUSTER: Yes.

DR. HOFFMAN: I will double check on that one. I know phase II is what I am talking about.

DR. SCHUSTER: Yes. And I understand that because that's a new study and that was going to go in a new direction, and the legislators control the purse strings had put that in there.

But we should be getting a final report from her, Leslie, on the completion of phase I.

DR. HOFFMAN: I will double check on that.

DR. SCHUSTER: Thank you.

DR. HOFFMAN: And again, I don't know if that stops us dead on phase II also, but I will follow up. I knew for sure it was phase II.

DR. SCHUSTER: I don't know, I will have to go look.

Bart, you might remember. There were a couple of hanging pieces -- or Michelle, may remember, that we got back

with Victoria to wrap up on phase I.

MR. BALDWIN: Yes, Dr. Schuster, it was really accurately completing the grid.

There was a grid on there for each code, and phase I, the two things -- I think the two main things to finish out phase I was to add in Missouri and Illinois for comparison for those states -- for the border states -- and the other thing was that there were several instances in the grid where the draft reported that they couldn't find the comparable code for another state and we had folks from -- I know Michelle with the Children's Alliance provided a lot of that -- links to those rates in other states, and we were provided some with ABA advocates as well.

But those were the two pieces that include the two states and they complete the grid where they can, because we felt that those -- we didn't find those, but we sent the resources to where we could find those.

There were a lot of x's, if you remember the grid it said that it wasn't unavailable, but in reality it is. So finishing phase I, I think was just those two things.

DR. HOFFMAN: So give me some time to ask, and again, Commissioner Lee is out too, and I know she was actually going to speak on that today. I just wanted to give you the information that we had.

MR. BALDWIN: Thank you, Leslie.

DR. SCHUSTER: Yes. I appreciate that, Leslie. I do think that those completion pieces on phase I were communicated back before the November meeting, so she has had that in her work thing before, maybe. This push came from the LRC, I guess it what I'm saying. It's possible that she was able to get those pieces finished.

DR. HOFFMAN: Okay. I will double check.

DR. SCHUSTER: Thank you very much. I appreciate that.

Let's go on. Jiordan had asked to be moved up on the agenda, and before we get in to the Myers & Stauffer -- are you all right with that, Leslie?

DR. HOFFMAN: Absolutely.

DR. SCHUSTER: Jiordan, would you go on and give us the information?

This is typically what Veronica Judy Cecil gives us on unwinding and recertifications, and I think you should be able to share your screen if you have something. There we go. Thank you.

MS. GRIFFIN: Okay. So you all see the PowerPoint, Medicaid renewals update?

DR. SCHUSTER: Yes.

MS. GRIFFIN: Okay. Thank you.

This is our Medicaid enrollment trend graph. It is really good to see that our enrollment is leveling off after the unwinding, after we ultimately had a drop in enrollment after the unwinding rules were rolled back. As far as maintenance of effort, it is stabilizing around 1,450,000 per enrollees.

DR. SCHUSTER: And that has been the last couple of months, or the last year almost?

MS. GRIFFIN: Yes. The dates are down here.

DR. SCHUSTER: Yes. Certainly since July of 2024. It's really been around that line. Okay. Thank you very much. That is good.

MS. GRIFFIN: So regular annual renewals for cases following the public health emergency, resumed in April 2024. We do have the flexibilities from the public health emergency in place through June of 2025.

There was information from CMS that outlined options to make some of the flexibilities permanent. These are still under consideration. And we are not sure, with the change in leadership over at CMS, if that will impact any of the recent informational bulletins that have come out or not, but we are still considering which ones we would like to make permanent.

We do have this Streamlining

Medicaid, Children's Health Insurance program and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes Final Rule -- very long name, but basically, that is meant to streamline application enrollment processes, improve retention rates at and between renewals, remove access barriers for children, and overall enhancements to program integrity.

We are currently still reviewing to see what updates we need to make based on that final rule from CMS as well.

DR. SCHUSTER: I'm sorry, Jiordan. We don't know whether those things are going to stay in place or not with the change in administration, right?

MS. GRIFFIN: Correct. Everything is kind of up in the air right now with the changes right now. We are moving forward with our current roadmap for implementation of these things until we hear otherwise.

DR. SCHUSTER: Okay. Thank you.

MS. GRIFFIN: Yeah. Absolutely.

And then we do have our CMS monthly and updated reporting that continues post-unwinding. So here is some report updates.

We have to report the updated renewals after the 90-day processing period, so we just reported September's numbers after the 90-day processing period.

So over here on the left-hand side is the original report, and on the right-hand side is our updated monthly report. Just showing that we had one pending renewal that was processed and added to the terminations column. It appears that they were not eligible and were terminated.

DR. SCHUSTER: They're eligible was terminated?

MS. GRIFFIN: Yes. If you look over here, we had Medicaid terminations with 1,234 with one pending. Once that was processed, we had an additional Medicaid termination listed. They were not eligible any longer for Medicaid.

This is the slide about renewals and reinstatements. We have a reinstatement period of 90 days where individuals can respond and provide requested information, and have their coverage reinstated back to their termination date.

So ones that are still within the 90-day window are still processing reinstatements and these numbers are included below.

You will see the most recent 90-day reconsideration period ended in December. We had 181 reinstated as of January 10th back to December when they lost coverage.

DR. SCHUSTER: So the numbers on the far right, that little box, are reinstatements -- for instance, 801 out of the 6,798 that had been extended for October?

MS. GRIFFIN: Correct. So October would have been their original renewal month, but they didn't respond or return information. They have come back

in to the Medicaid program and had their eligibility reinstated, so that is the total over here, reinstatements.

So 801 individuals have been reinstated back, because they responded within the 90 days to be reinstated.

Subsequently it's 750 for November and 181 so far for December.

DR. SCHUSTER: And they have 90 days?

MS. GRIFFIN: Yes. That is correct.

DR. SCHUSTER: Okay. Thank you.

MS. GRIFFIN: Yes, absolutely.

Additional resources, as always, are included on our PHE website. We continue to post new information and updates regarding renewals, even though we are kind of post-unwinding period, the medicaidunwinding.ky.gov website.

As always, the message out -- notice here at the bottom, still applies. We still have people who aren't responding to renewals or maybe don't know that they need to complete a renewal. We have

informational flyers available in English and Spanish for anybody who wants that information to be able to pass out to members.

And that is it for me. Thank you all.

MR. SHANNON: We lost Dr. Schuster.

MS. BICKERS: I was just getting ready to ask if we lost her.

DR. HOFFMAN: Let's give her just a minute, Erin.

MS. BICKERS: I think she dropped, so she may need to log back in.

MR. SHANNON: She said she got kicked off.

DR. SCHUSTER: I am back now. Sorry about that.

Did we lose Jiordan or did we just lose me?

MR. SHANNON: We just lost you. She was done.

MS. GRIFFIN: We just lost you. I'm so sorry.

DR. SCHUSTER: Okay. All right.

Well, I am fine. I thought we had lost you and then I guess I got kicked off. So much for the Internet.

Jiordan, would you send your PowerPoint to Erin, please?

MS. GRIFFIN: Absolutely. Yeah. She should have copies of it to disseminate out.

DR. SCHUSTER: I asked some questions as you went along. Were there any other questions to ask Jiordan about the unwinding and recertifications?

Okay. Thank you so much, Jiordan. Appreciate it.

MS. GRIFFIN: No problem. Thank you all.

DR. SCHUSTER: Dr. Hoffman, we will go back to you and whoever is with you from Myers & Stauffer, to give us a summary of Kentucky's statewide needs assessment, please.

DR. HOFFMAN: Is that next on the agenda, Sheila?

DR. SCHUSTER: Yeah.

DR. HOFFMAN: Okay. So I have

got Amy Caron with me.

MS. BICKERS: Dr. Hoffman, does anyone need to screen share so I can make them a co-host?

MS. CARON-FRANKEL: I just sent a request. Thank you. Sorry. I should have done that earlier, Erin. I saw the button, and I thought it could work.

DR. HOFFMAN: I should have said something, too.

MS. BICKERS: No problem. There you go.

DR. HOFFMAN: So just to start out, Dr. Schuster, if you remember, I sent you some emails over the last couple of weeks.

We've had some minor changes just because we had a little bit more time to look at it, and really the modifications are more about just having a clear communication kind of thing.

So we are going to go over today the statewide behavioral health needs assessment, and we are very excited about going over that with you today.

So just some background, the behavior health needs assessment was initiated based on the original guidelines and the guidance that was from the 2023 US Department of Health and Human Services criteria for our CCBHC providers here in Kentucky, and that is our certified behavioral health clinics related to their certification.

It recommended that states develop a statewide behavioral health needs assessment to identify community needs and to determine program capacity to address the needs of the population that are being served across Kentucky.

As you may know, we are currently evaluating how we can expand the demonstration, the CCBHC demonstration, to additional providers so it is very important for us to follow all of the guidelines that are set for us.

I would just like to note that the assessment represents a snapshot in time. I know you all get tired of us saying it sometimes, but this was

definitely a snapshot in time and it presents information that was available during the assessment process.

There has been a lot of work that has went on and I would like to give a big shout out to everybody who has helped with that. Medicaid, Myers and Stauffer, our contractor, as well as the Department of Behavioral Health. Lots of good work is going on across the state.

And we anticipate that this is actually -- if you noticed, Dr. Schuster, when I was talking to you earlier -- we considered it a draft, it is a living document, and we want to continue to add to this living document as this initiative goes forward and progresses.

So this is the PowerPoint presentation and I will have Erin send it to you as soon as this presentation is over.

Next slide, Amy.

Just to go over the purpose of what will be discussed today is the purpose of the needs assessment and the

methods used to complete it.

What we found in our research, what we discovered in our research and through our partnership engagement and our partner-driven and best practice recommendations and opportunity, and then we will, of course, go through some takeaways and potential next steps.

Next slide, Amy.

So this is getting started with the introduction and I'm going to turn this over to Amy who was a big help to us in completing this needs assessment, and we'll go over the introduction, the purpose, the needs assessment, and our approach.

So Amy, I will turn us over to you now.

MS. CARON-FRANKEL: Dr. Hoffman. Thanks y'all. So you can see my screen and hear me, right?

DR. SCHUSTER: Yes.

MS. CARON-FRANKEL: Great. Thank you.

So the goals of the behavior

health needs assessment are really to identify and understand behavioral needs and gaps, which I think you all know in the current system of care.

The findings can be used to inform policy, program development, improve access and availability of proper services, and enhance outcomes and promote equity in the behavioral health system of care.

One of the most important aspects of our methodology was establishing the behavioral health collaborative work group, which met regularly throughout the project to guide all aspects of the execution of the behavioral health needs assessment.

The group included leaders from DMS and the Department for Behavior Health and Developmental and Intellectual Disabilities, and we are so grateful for their oversight and decision-making, because this really promoted a sense of transparency and collaboration from the start of the project.

With the collaborative work group, we determined a specific set of research questions that were then used to guide the various inputs that you see here which included a review and catalog of documentation to map available resources, research of population health needs and best practices, partner engagement, which we used to collect quantitative data from behavior health and primary care providers through a survey, and qualitative data through interviews, focus groups, and questionnaires.

We conducted an analysis of available state and national data, as well, such as from Medicaid claims and MMIS, Kentucky Hospital Association, SAMHSA, CDC, to identify some trends and disparities.

Here are just some stats on the methodology. We reviewed over 120 state documents and literature sources. We analyzed nine key public and state data sources to understand the need.

We created 12 separate in-depth

population profiles, which were determined by the behavior health collaborative work group.

We engaged with 63 individuals representing 53 organizations across the landscape which included behavioral health providers, primary care providers, advocacy groups with individuals with lived experience, community supports providers, health plans, associations, and of course, state agencies.

And finally, we received 351 completed responses to the behavioral health and primary care survey.

Behavioral health statistics can help illustrate the scope of the needs and I think you're gonna -- I'm going to go through these really quickly so we can get into some of the others.

I think you all are probably familiar with a lot of these stats already. Kentucky residents tend to have higher rates of depressive disorders and mentally unhealthy days throughout the nation; suicide is a leading cause of

death; youth are disproportionately affected by the behavior health care conditions; and though the overdose rate has been decreasing, Kentucky still ranks seventh in the nation.

When looking at different populations, when looking at a composite measure, Kentucky ranked 36 for youth with high rates of mental illness against access to care, but that wasn't really seen in that same study for adults.

Seventy-five percent of youth with major depression did not receive care compared to the national average of about 60 percent.

Veterans have higher rates of suicide than national averages. Almost 60 percent of youth identifying as transgender have seriously considered suicide, and over 12 percent of older adults have frequent mental distress.

Looking at the Medicaid population specifically, over half reported experiencing 1 to 13 days of poor mental health over a month period.

Regionally, Eastern Kentucky had the highest proportion of adults reporting poor mental health, specifically in regions 8, 9, 10, 12 and 13, all reporting over 20 percent.

Eastern Kentucky also had the highest rates of behavior health-related emergency department visits in 2023.

Southeastern Kentucky and Appalachia have the highest needs related to the safety net, so there are more lower income individuals with higher rates of little to no insurance coverage, world geography, and of course, transportation challenges, and English proficiency.

Looking at overdose -- I know I'm going through these fast.

Looking at overdose death rates across the state, Breathit, Owsley, Lee, Estill, Powell and Menifee were all among the highest, and Carlisle and Hickman counties had the highest suicide rates in the state.

So now we start getting into Medicaid claims data. Looking at specific

provider types to look at service utilization across what was categorized as inpatient hospitalization, residential treatment, partial hospitalization, outpatient services, and the provider types under those categories was determined in collaboration with the behavioral health collaborative.

So looking at the last five years, there has been a steady growth in lower intensity services, partial hospitalization and outpatient services, although there is still significant use of emergency services, especially for substance-related diagnoses in Eastern Kentucky.

There has been some growth in inpatient services, but not as substantial as lower intensity services and residential services has been somewhat consistent.

While access to lower intensity settings has expanded for Medicaid members, utilization of behavior health services has risen overall, and we haven't

seen any substantial increase of utilization in higher intensity settings.

Next, we looked at the number of providers fitting the definition of each type of, again, in-patient hospitalization, residential treatment, partial hospitalization, outpatient services.

There has been 29 percent decrease in outpatient providers. Twenty-nine percent of outpatient providers during the five years we reviewed, but again, as we know, behavior health needs continue to rise.

There hasn't been nearly the same amount of growth in higher intensity providers, and the number of residential treatment providers remains consistent. And we did not have data for partial hospitalization.

DR. SCHUSTER: Amy, when you talk about providers, are you talking about licensed mental health behavioral health providers or are you talking about providers that also include peer support

specialists and --

MS. CARON-FRANKEL: Yeah, and we can add this to the slide. So it doesn't include, like peer support, so I can just run through it -- again, it's not on the slide, but I can include it in the version that we can send around so you have it for easy reference.

Inpatient hospitalization, psychiatric hospital, psychiatric distinct part unit, the DPUs, rehabilitation DPU. Residential treatment and short-term services includes psychiatric residential treatment facilities, level I and II, residential crisis stabilization unit, and immediate care facility for individuals with IDD.

Partial hospitalization includes chemical dependency treatment center, and outpatient includes CMHC, BHSO, CCBHC, and the behavioral health multispecialty group.

DR. SCHUSTER: And again, my question is, even with the CMHCs or the BHSOs, or the partial whatever, are most

of the providers you are talking about licensed professionals or do they also include lower-level, if you will, peer supports and ABA technicians, and so forth. That is what I am trying to get at.

MS. CARON-FRANKEL: I am wondering if Martin -- Martin from Myers & Stauffer, are you on?

It maybe something that I have to take back to the analysts.

MR. MCNAMARA: Yes. I'm sorry. Can you repeat the question?

DR. SCHUSTER: I am trying to get down to the provider level, not the facility or setting. I want to know if we are talking about licensed -- individually licensed mental health SUD providers. In other words, they have a statute, they have a board, they have criteria, and so forth.

Or when you talk about providers, are you also including peer support specialists and technicians and those kind of things?

MR. MCNAMARA: It would be the providers as they are registered, in this context with Medicaid. So if they have different provider numbers they would be counted differently, but that would just be if they billed, say, under another provider, they would be counted together.

DR. SCHUSTER: The reason it is so important to me is we have had a million discussions -- hours of discussions -- here in the BH TAC about things like peer support specialists and those services, which are qualitatively different than a clinical psychotherapy session. That is what I am trying to get at.

MR. MCNAMARA: Mm-hmm.

DR. SCHUSTER: And I'm trying to figure out what your data really tells us.

MR. MCNAMARA: I am not sure about the specifics of that. We may have to look into that further.

DR. SCHUSTER: Well, I would encourage you to do that because it is a really an important question.

So when we talk about provider workforce, we can't just use provider to mean anybody who ever gets a Medicaid payment, because the range is great. And we are trying to concentrate on -- because we really don't have good data -- on how many licensed mental health and SUD providers we actually have that are functioning in this state, because the licensure boards don't have that information, and that is what we are trying to get at. You all have a wealth of information, and I am just trying to get at some issues that keep coming up.

MS. CARON-FRANKEL: Yeah. We can take that back. This is all -- this would be MMIS data, right, Martin?

MR. MCNAMARA: That's correct. Yes.

MS. CARON-FRANKEL: And we have run into this very question with work in other states, too, in trying to understand from a licensing perspective what the landscape is, but we will take it back and try to, you know, look through it again.

DR. SCHUSTER: Yeah. It's difficult. We ran into this with Victoria on the rate study when she was trying to compare Kentucky with other states and we were trying to get at how are you defining who these providers are. So it really is an important question, I think.

MS. CARON-FRANKEL: And it gets to -- no, I'm sorry. Go ahead.

DR. SCHUSTER: Just that it is a workforce issue and there is group that is working on workforce, I am always concerned about whose work are we looking at, and who is doing what services, because not everybody can do all services, and the MCOs were complaining about how much they were spending on services that they did not consider to be clinical services, which means they were not delivered by a licensed clinician, so I am trying to get at that and you all have this data.

My other question, because Leslie started out with this is a snapshot in time, I didn't hear for you or hear

about what is the time frame during which you were conducting the study for this information?

MS. CARON-FRANKEL: Yes, good question. This started late October of 2023, and we just wrapped up a couple of months ago, so I would say that the data pulls would have been early 2024.

I'm sorry, Martin, this data goes the last five years -- 2019, I think?

MR. MCNAMARA: We had that available for some things, but for this display, it is 2023.

MS. CARON-FRANKEL: For this -- yeah, sorry, yeah.

DR. SCHUSTER: Let me ask, Shannon Stiglitz has her hand up.

Shannon?

We'll come back to her.

MR. SHANNON: Sheila, would it help the process if we delineated those providers specifically? We have a list for peer support, community support associate, targeted case manager, associate level independent practitioners.

DR. SCHUSTER: We could provide that to you. I don't know how you get that data and what categories MMIS gives it to you.

MR. BALDWIN: All of those categories are defined in the fee schedule and you have to have modifiers that delineate who is delivering the service, whether that is a licensed associate or what level, so I think that that should be identified. I mean, it's defined within the fee schedule.

MR. OWEN: This is Stuart Owen with WellCare, jump in real quick. Sorry.

So the individual, the licensed clinicians, they will be credentialed and affiliated with the MCOs, but the ones like Dr. Schuster is talking about, the peer support specialists and others, those are not individually captured in any way. The ones like that, so I am thinking, I don't think that would be in the MMIS, in other words. They are not individually affiliated.

MR. SHANNON: Right. The

service would be there, right, Stuart?

MR. OWEN: Yes. You could see the service, the modifier, and you would know it was done by somebody who is a peer support specialist, but I don't think we would actually have the actual numbers of the peer support specialists, et cetera, paraprofessionals, basically.

MS. CARON-FRANKEL: This gets in to the limitations of the state data that we have the access to.

DR. SCHUSTER: Yes.

Shannon, are you ready now?

MS. STIGLITZ: Yes. I couldn't -- for some reason it opened Teams and instead I was trying to get off mute on Zoom.

I apologize. My question really goes to the data and can you add additional information?

For example, regions are very different in size, number of providers, especially across these various categories.

For example, if you look at

NorthKey outpatient, there are three claims per provider type, but you look at inpatient, there are 30 claims per provider type. And I know that this is unrealistic, but you might only have one provider.

How many providers fit within these categories or the number of claims per provider in my opinion, don't really -- it doesn't tell you anything.

For example, you are going to have very rural regions and you are going to have very urban regions, and I think it is -- common sense dictates how those claims might vary, but it would be very helpful in my opinion.

I guess I don't know what, in some respects, the point of this slide is without additional information. I don't know if you can really glean anything.

And I am new to the behavioral health world, so Dr. Schuster can tell me -- I am not new to the Medicaid world, but I'm new to the behavioral health care world, so she can tell me I am crazy, but

that is my thought. If you can add some additional data.

MS. MILLER: I just have a question. Does this also include the non-licensed people that provide counseling services at the comprehensive care centers? Like the people that are in Bachelor's level who are providing counseling services that don't even have a license or a Masters degree?

DR. SCHUSTER: The mental associates? Is that what you are asking about?

MR. SHANNON: Yes.

MS. CARON-FRANKEL: Martin, I wouldn't think that it would, because again this is at the facility level, right?

MR. MCNAMARA: Right. It wouldn't count them as separate providers.

MR. SHANNON: When it says, like, region I, Four Rivers, is that Four Rivers data, or is that data from those counties in the region?

MR. MCNAMARA: That data is

identified by the county in the region so it's not from the organization.

MR. SHANNON: So when you see NorthKey, with 30 inpatient hospitalizations, that does it per thousand members, that is a reflection of the eight counties in that region, right?

MR. MCNAMARA: Yes.

MS. STIGLITZ: I guess in my mind, Steve, without knowing the number providers, without knowing -- even inpatient hospitalization and the provider type, because you can have 02, 01 -- I don't know that you are getting a clear picture of utilization. Or, let me say it differently, where are services needed in regions and in communities?

DR. SCHUSTER: Yeah. These numbers don't make any sense to me because some of the most heavily populated --

MR. SHANNON: Well, the three largest --

DR. SCHUSTER: The three largest have the smallest numbers of outpatient. So what is that outpatient telling us?

Seven Counties and NorthKey.

MR. SHANNON: Yeah. And even new Vista --

DR. SCHUSTER: And New Vista is really low. And then you've got Kentucky River, which is very rural in Eastern Kentucky, with a tremendous number. I guess I don't understand what these numbers reflect.

MS. CARON-FRANKEL: So I wonder -- there is a detailed document that goes with this that part of me thinks may be helpful.

I know that Dr. Hoffman is signing off on those, and it may be helpful to see all of this in the greater context. We were kind of picking some pieces out of it to show you all to try to present prior to getting all of the documents and there may be, you know, all of the context in there. But there is also limitations in the data that we have.

I think getting to the full denominator of providers, especially outside of Medicaid is the challenge.

This data, particularly, has limitations. But again, maybe in the full context of the document in its entirety, again, may help.

And this is also a starting point. I think there will be, there are other workforce initiatives and other things where other data can be layered on to this as well, but this is, again, just a snapshot of the Medicaid data that we have access to.

MR. PATEL: Can I ask a question? This is Chirag. I'm sorry to interrupt. I just have a question.

Amy, this is fantastic data. I totally understand the limitations of gathering data in the Medicaid world, so kudos.

Will you guys be releasing recommendations with your data or just releasing data, because I would have consternation if you had recommendations being released with the data knowing its limitations, right? Because then it could be misconstrued.

MS. CARON-FRANKEL: Yeah. So we will get to some of the recommendations and it's important to note with the recommendations and with the part that we will get into, that it is partner driven.

We had a lot of conversations with community members and other providers and, of course, across state agencies, so you will find that the recommendations -- and again this is a starting point, it is kind of a place in which to build and pick apart, and analyze, what do we need to do some further analysis on, and what do we need to further drill into to sort of really build this out?

So I wouldn't say recommendations based on this data only, no. There is some additional inferences, but that is really to generate more research questions. What other data can we, again, layer in try to expand the story here, but to say that we make recommendations based on this data alone, no.

MR. PATEL: Okay, perfect. I

appreciate that. Thank you so much.

MR. SHANNON: And just as another concern, Seven Counties, NorthKey, and New Vista, are approximately close to 50 percent of the state population, 45 to 50 percent. Comprehend is about one and a half percent of the state population.

Comprehend comes in at 498 claims per thousand members, and the other three close to half coming in at 67. I mean, it really, on the surface, it doesn't seem to make sense to me if it is done by region. Knowing what I know about the regions and the population, it's really hard for me to get to region 6, and region 7 and region 15, compared to what is the smallest region by population.

MS. ALLEN: Steve that's a great point. This is Jodi Allen, a behavioral health specialist with DMS.

I just want to mention that we just did an assessment of availability of providers across the state, as a piece of our 1115 application to CMS.

I think, honestly, we broke ours

down by MCO region, and I think if you cross-reference this with that, it would probably make a lot more sense.

So I don't know, Amy, if you all had access to that or if anyone had shared that with you, but I do think that it could be helpful in looking at this again and maybe considering some options for breaking this out a little more.

MS. CARON-FRANKEL: Thank you. Yeah. I did not see it. So, yeah.

MR. SHANNON: We appreciate your work, Amy. We just want to make sure it makes sense.

MS. CARON-FRANKEL: No. Let me say -- and I don't know if we talked about this at the beginning, but it's meant to be a living document. This is meant to be, again, a starting point to be picked apart and to say exactly what Jodi -- it is good to hear from you -- but exactly what Jodi had mentioned.

We also did this if we try to layer this and look at it that way, we can piece it together or understand the story

a little bit better.

So absolutely. It is a place to start and it is a place to build from and add to overtime. So this is --

MS. ALLEN: I would say, honestly, Steve, in regards to your question, there are so many other types of providers in the urban areas, so in the more rural areas, obviously the CMHCs are covering more ground, and we actually saw that in our data too.

MR. SHANNON: Again, if I understand it correctly, this isn't --

DR. SCHUSTER: This isn't CMHC, it's all Medicaid.

MR. SHANNON: This is the geographical region.

MS. ALLEN: Right. Right. And breaking it down to the eight MCO regions, it captures it differently.

DR. SCHUSTER: So there was a question in the chat, Jodi, whether the data that you gathered is available.

MS. ALLEN: It is not. It is actually -- I will have to double check on

that. I think that we can share more internally because it is not a public document, so I will have to check on that Sheila, but I will. I will take that back.

DR. HOFFMAN: Jodi, is part of that what's lying at CMS for approval?

MS. ALLEN: It was actually something that we submitted as part of our application, but it is not in the public documents that they put out.

DR. HOFFMAN: Usually we wait until we go back-and-forth with CMS until they know that there is something wrong and we need to correct something before we send those documents out to the public, but they eventually will be available.

MS. ALLEN: Yes, but I can double check.

Okay, Dr. Schuster?

MR. SHANNON: I think she is frozen. Yes. We will pass that on.

MS. ALLEN: Okay.

MR. SHANNON: Sonya Carrico, do you have a question?

MS. CARRICO: Yeah, I did. I have some of the same questions everybody else did, but I'm thinking about how to interpret this information moving forward.

And as you already pointed out, Steve, some of our more populated regions have the lowest numbers, so that makes me wonder what the population density is for these regions so we can see the number of Medicaid members compared to the population, because my mind also starts to assume that in Seven Counties, NorthKey, New Vista, we have fewer people on Medicaid, and I don't know that that is true. But knowing those things kind of leads me to some other questions about access and who is providing services that would come next.

MR. SHANNON: With a thousand -- claims per thousand members flatten that out? Was that the intent of that, do you think? Either Amy or Sonya?

MR. MCNAMARA: Yeah, that was the idea of this, but I think to the points made earlier, that this was more to

show the points in utilization of the different provider types.

Like Amy said, these are really facility based, and this might be pointing to that rather than members in Seven Counties and NorthKey going to these types of facilities, they are going to other types. And there is more detail on which types of facilities are included in each of these in the report.

So I think this really just points to the utilization of services is quite different between those urban and rural regions.

MS. CARRICO: I think that could be in part because of what is available and what is accessible in those areas. If we understood the access points, that may explain why more people use outpatient versus residential in some communities or others.

MR. SHANNON: Right.

MS. CARRICO: Because if it's not available, then these numbers are going to be low and they are going to be

higher in the other categories.

It doesn't necessarily indicate that that is where the patient need is and that we really need to think more about ramping up outpatient services because we see high numbers there. That just means that was available at your point in time.

MR. SHANNON: That makes sense.

Sheila has been kicked off again, so we'll just go ahead.

Do you want to keep going, Amy?

MS. CARON-FRANKEL: Yes, thank you. This is the exercise. I appreciate the discussion and the questions around this, so thank you.

MR. SHANNON: There was a comment about more populated regions having lower -- where is that comment? Lower density maybe?

"Could one interpretation be that the information that more populated regions have lower density of providers than rural?"

Quite possibly. That is a good point, Jared.

We have been talking about the impact of rural versus urban areas for years, and that is one of the issues that we quite often discuss.

I still don't get the disparity, to be truthful. Single digits for two of the largest, but anyway.

MS. CARON-FRANKEL: Thank you. Again, it is another potential inquiry. It's another drill into the data to be able to understand so it is a valuable exercise to be able to look at the data and pull it apart like this and to be able to ask those very questions.

MR. PATEL: One provider type be -- under 110, right? But there is multiple dispensers of clinical care under 110. Is that a possibility in the outpatient data? Because I do agree, right?

Steve, I you are 100 percent right. How is it that NorthKey or Seven Counties has just four, right?

But is that like, for example, a provider not to be named, who is out there

dispensing tons of care, actually, but under 110 with multiple dispensers of clinical care, i.e., you know, the ones who have been in the newspaper here recently, and who are under investigation by the Attorney General, right?

Not to be named, but I am just trying to figure out, there is all of that nuance within the subtext of the data, and then, you know, bad care drowns out good care. That is a data science phenomenon, fadeout, right?

So when you have fadeout, one intervention drowns out the other intervention. It is not that it is better or worse, it just drowns it out and creates background noise in the data. So actually, if you have a lot of outpatient or lower-level services, just by default, people don't get higher-level services or inpatient care, right?

It's not that there is not enough inpatient care, it is just because there is a drown-out phenomenon.

And so you have to do multimodal

regression analysis to figure that out, and I don't know that your data set is structured that way, but since you are nodding your head, Amy, what I am saying is probably resonating with you, and my fear is without that level of appraisal or scrutiny of the data, you will have aforementioned non-said providers taking that inference to say we just need more providers to come to these rural counties, where it is actually the opposite.

DR. PATEL: You know, the ARCs of the world will put more providers out there and run mills of clinical care just as --

DR. SCHUSTER: Dr. Patel, we are not going to throw people under the bus. Do not name other providers, thank you.

DR. PATEL: I apologize. You can strike that from the record.

Anyway, I thought I would share that there are some limitations to the data, and we can put that on the record, though.

MS. CARON-FRANKEL: Thank you.

Dr. Schuster, I know you got kicked off and you got back on. I know you have a lot of other items on your agenda. Are you okay if we continue?

DR. SCHUSTER: Yes. I think we want to see what you've got here. Thank you.

MS. CARON-FRANKEL: Here -- and we are looking -- and this is strictly at SAMHSA data -- and they're looking strictly at locations of behavioral health providers. This is CMHCs and non-CMHCs.

Here when you look at the areas of need, like the western counties like we talked about -- Hickman, Carlisle, and Union, they have the higher rates of suicide and self-inflicted injury, central regions, Breathit, Owsley, Lee, Estill, Powell, Menifee, with high rates of overdose, and Meade and Hancock and McLean with the lower safety net scores.

With this data you are seeing that the providers are a little bit more geographically sparse.

There is a trend that we are

seeing here in this data, that we were kind of talking about on the surface. Providers are a little more sparse in the rural areas. If you look strictly at this data, BHOs and CMHCs by region, you will see that one to four have lower provider to member ratios overall. And there are a lower number of providers in region 8.

And again, you all will have the detailed report here and I think is far as these questions as far as where the data goes next and what we do next with it, those questions that are coming up with this data are going to be really, really helpful. This is really just to get the discussion started.

MR. SHANNON: Can I ask a question on that last slide? I'm sorry.

MS. CARON-FRANKEL: No. That's okay.

MR. SHANNON: Seven Counties has 10 CMHCs? Kentucky River has 11?

MR. MCNAMARA: These would be provider locations, not necessarily --

MR. SHANNON: Four Rivers has

more than one location.

DR. SCHUSTER: Yeah. I think all of these --

MR. SHANNON: It's either or, and if that is the case -- New Vista, I rent property from New Vista, and they have a location in this area, 100 feet from me, 500 from me, and they've got one three blocks from my house. So I can verify right now that the New Vista data is wrong. I have two locations that I can get you to immediately, plus their main office.

And Communicare has multiple --

DR. SCHUSTER: Dr. McKune from Seven Counties says Seven Counties has more than ten locations.

MR. SHANNON: Yeah.

MR. MCNAMARA: Yeah, that might just be how the data is reported. We can look at that more and see if we can figure out exactly what happened there.

MR. SHANNON: Yeah. That makes sense.

MS. CARON-FRANKEL: We are only

as good as the data and this context is so helpful. This context is really helpful.

MR. SHANNON: The data and the question.

MS. CARON-FRANKEL: And the questions, right. Again, this is just, here is what the data sources tell us on the surface, and all of this context and the layering of all of the other data sources and what we know on the ground and what you all know is really very helpful to then scrutinize the data in other ways.

Okay. Throughout these next slides, we are going to look specifically at the partner engagement findings. We did interviews and focus groups, questionnaires, surveys, so we gathered all of that information and came up with some key themes.

Again, this is high level and the report itself goes into a lot more of the meat, and again, this is all from partner discussions and partner information.

When we talk about strengths,

partners really underscore the state's commitment to improving behavioral health, and they continue on through groups such as this one, targeted task forces, committees, counsels, that are focused on these efforts.

Partners also highlight the impact of CMHCs and various integration models that have been employed in the state, and they were really excited about the CCBHC model and the CCBHC expansion efforts that are upcoming.

Medicaid expansion was, of course, also mentioned to increase access to coverage, and partners supported the expansion of the roles of peer support and peer support programs, and expanded Telehealth coverage in Medicaid.

Other interventions were discussed, especially co-response, the co-response grant program, 9-8-8 call centers, mobile response for children, and local efforts in crisis call diversion programs.

And of course, investments to

address the opioid epidemic were discussed quite a bit, namely KORE, and Find Out Now resources, bridge clinics, and in-home therapy programs.

We were also able to talk through some of the efforts -- some of the new efforts around the 1115 waiver and 1915(i), which increases funding to support justice-involved populations and adults with SMI and SUD.

Support initiatives focused on pregnant women and postpartum women and infants with neonatal opioid exposure and women receiving that.

The state is also doing a lot, as we talked about, to address behavioral health workforce challenges. The workforce innovation development collaborative, which is very active. It is a multidisciplinary effort to review, design, and implement, and evaluate policies and programs and practices to improve the workforce and retain the workforce.

A couple more focused

initiatives came up in our discussion. Multi-systemic therapy pilot program, that is currently in evaluation. The Kentucky Court of Justice, advancing a recovery-oriented system of care model. That's also through a collaborative process to get children to appropriate services from the justice system. Partners also mention that as a strength.

Partners talked a lot about various health equity initiatives and the health equity focus for the state. This is the top, I think, of five priorities in the CHFS strategic plan.

There are specific initiatives in advancing equity through hiring, procurement, utilization of racial equity tools to evaluate programs and impact, and disaggregating data to uncover disparities and outcomes to target various campaigns and efforts.

So strengths, those are again, high level, there is a lot more in the report, but we will get into some of the challenges that are high level. None of

these were really surprising, and these are common it challenges that other states are also facing the same.

As mentioned previously, we had 351 survey respondents, and these are behavioral health and primary care providers. So you will see that there is -- what is it -- three quarters of primary care providers and over half of behavioral health providers disagree or strongly disagree that the behavioral health system is meeting the needs of all Kentuckians.

When you look at specific groups that they perceive the least likely to receive the services that they need, behavioral health providers noted adults 65 or above, of course individuals that are not insured or underinsured, and Black African Americans are those that are least likely to receive the supports that they need, and primary care providers noted adolescents ages 13 to 19, and Latino, Hispanic, and of course, again, individuals that are not insured or

underinsured as being those that are the least lightly to receive what they need.

Challenges, reimbursement, and funding was the most widely discussed. Namely low rates, reimbursement issues, claims, denials, delays, low network coverage. All of which reduce the number of providers participating in Medicaid and with commercial insurances and reduce the availability of services.

Lower pay and limited funding, of course, can also limit the necessary community-based programs that can support the behavioral health system as well.

Workforce shortages, it is a known challenge. I know we talked about a little bit so far, and maybe more challenging in rural areas.

Partners talked about specific consequences of that. Of course, longer wait times, but the overutilization of nonclinical or higher intensity services in the absence of other services that are needed, such as an over-reliance on peer supports or APRNs or other

paraprofessionals, which can lead to misdiagnosis if that is what they are doing, or poor management and oversight of treatment.

Also it can contribute to burnout of these valuable professionals as well.

Providers did underscore that participation in managed-care as well as commercial insurances with various policies and procedures is an ongoing challenge as well.

Gaps in the behavioral healthcare services that are available, namely, housing came up quite a bit and recovery supports. We talked a lot about the need for comprehensive eating disorder treatment facilities, and services focused on children and youth, which is a population that is experiencing rising rates of behavioral health conditions and that is across the nation.

Partners also discussed fragmentation and limited care coordination and collaborative care.

Citing privacy concerns, lack of training, administrative burdens, lack of data sharing in irreparable systems came up quite a bit as factors that limit care coordination.

Talking about health-related social needs, this came up a bit also. While the providers understand the need to assess patients for health-related social needs, many of them said I can't assess for something that I can't help to address.

We know that Kentucky Find Help Now might be a resource that is helpful, but it is not something that all of the providers that we spoke to knew about. So sometimes a lot of these things just end up being a lack of awareness of what may be available.

Opportunities and recommendations, again, these are from partners mainly. And some best practices that we have seen in other states, but again, this is all really generated from partner discussions and partner feedback,

so this is coming directly from community members.

Kentucky is working to increase Medicaid rates overall, but partners underscored the need to continue to think creatively, how do we further support the workforce through funding and incentives. There are loan repayment programs, but there was cited a need to evaluate the effectiveness of those programs.

Other recommendations include career assistance support, home buying programs, childcare stipends, signing bonuses, postgraduate support, things like reducing the cost of licensure, cross-licensure, all things that may be helpful to recruit and retain members of the workforce.

They also mention coverage parity and the need to ensure parity and reimbursement.

The minimum wage also came up as far as the healthcare workforce specifically to retain the workforce. There are a lot of comparisons across

working within a community-based organization to working at Starbucks or working at McDonald's, and how am I going to keep my people here, if they can make more money over there?

So that came up as far as a recommendation for how to raise the minimum wage.

Addressing provider work force shortages is a key priority in supporting the workforce is a key priority for Kentucky. Partners cited the need not only to increase the workforce, but to potentially expand the reach of existing professionals.

And we mentioned peer supports, but also community health workers, and even occupational therapists as including in as paraprofessionals.

As the utilization of paraprofessionals expands and continues, they must be supported by professional organizations, standards, and oversight to avoid overutilization, inappropriate utilization, and burnout.

In that same context, partners talked about Warmlines and expanding Warmlines to offer behavioral health support outside of emergency crisis situations as a better way to utilize paraprofessionals while offering a valuable service to the community.

Telehealth, of course, was discussed a lot. Partners underscored the need to continue to support broadband efforts and Medicaid expansion to continue to increase access to Telehealth, especially in the rural areas, but also in schools.

We talked about Project ECHO which there are a couple of ECHO sites in the states, which is a professional mentorship program that can bolster capacity of local providers.

Creating a statewide training program as a public pilot consortium could help build capacity of professionals across the continuum and ensure that existing resources are fully maximized, and this could include local academic

institutions, how do we increase the pipeline, and secure the pipeline of professionals? And this infrastructure could also be used to ensure providers are up-to-date on billing practices and appropriate billing and correct billing and any billing changes and things like that.

Integrated care models are, of course, widely cited as effective strategy to bolster behavioral healthcare and access.

To implement integrated care on a statewide level, partners discussed a need to increase collaboration and communication between existing committees, workgroups, and other government structures to create a singular vision that everyone is rolling towards and working towards.

BDID, we know, is beginning to examine and evaluate what integrated care models are in practice, but, again, having a statewide vision can help further that expansion and, of course, there is a lot

of federal funding to support any of those efforts.

Addressing known gaps in care, of course, that are identified, including reviewing funding, policies, legislation that either are needed to support addressing those gaps or hinder expansion of those needed services was also discussed.

Finally, continuing the focus on health disparities and health-related social needs. A lot of partners talked about the importance of community-based organizations, including the CCBHCs, CMHCs as the local trusted resources to serve the very needs of their local communities because they know the communities best.

Partners talked again, about, that need for screening for health-related social needs. When asked if they conducted those assessments in the survey, it was 18.4 percent of behavioral health providers said they didn't do an assessment, and 21.6 percent said they didn't know if they did that assessment.

PCPs were more likely -- about 34 percent -- said that they either conducted a screening as needed or on every visit. But again, there is still that concern of, if I find an issue, I need to know how to help them, and I need to know where to refer them if I find that there is something that they need help with. And there is the SDOH Medicaid Data Project, which is really cool, which helps to address that concern by connecting the assessment project to Kynect for ease of referrals. So expansion of that and the ongoing support of bringing that to the community would help to address that need.

Other opportunities, of course, including, continuing to support health insurance enrollment, partnering with community-based and local organization, expanding the connectors, maybe bringing them to schools, and increasing access to free, low cost, supported training on cultural competency and standardization of an equitable screening process.

A couple more things.

Managed-care and managed-care participation was widely cited as a challenge, again, to work with all of the various policies and procedures, and looking at how to standardize performance measures and ease the burden -- the administrative burden -- across the board was talked about a lot.

Overall, as you all know, there are a lot of great initiatives and programs designed to improve the behavioral health system of care overall, so looking at how do you evaluate what are the key metrics and how do you regularly report coming up with that way to continuously evaluate the behavioral health care continuum as you rapidly expand is also something that is important to consider.

So key takeaways and some next steps.

I think the first thing that it is important to really underscore is that Kentucky is not alone in these challenges. These are national challenges that other

states are also working through to improve their behavioral health continuum of care. And they provide us examples and some lessons learned as well.

Kentucky also benefits from really dedicated partners and there is just such a high level of commitment across all of those that touch the behavior health care system of care and behavioral health workforce, and by leveraging that dedication, you guys are going to continue to move things forward and develop that roadmap and that vision and strategies and actual actionable steps to achieve that.

I know Dr. Hoffman had said this early on, but this was just a super high level overview of what is included in the behavioral health needs assessment.

There are five documents that you see here. These documents go far more in depth than we were able to get through today, of course.

All of these documents were reviewed for a long period by

representatives at DMS and BDID and they are with Dr. Hoffman now to finalize and I think that after signing off we should be able to share them with you all to do a real deep dive.

And I know that Dr. Hoffman mentioned again, this is a snapshot in time. We are as good as the data we received and as good as the information that we were provided, but it is a good starting point. It is a solid starting point, and these will be living documents and as you review them, you look at the data and you look at what came in through partner engagement, and it is a place from which to start. It's a place from which to build.

There are many initiatives, obviously, now that are underway that will be important to continue to add to this statewide needs assessment.

It is a good starting point and a solid referral source as we are looking to develop further strategies to expand the behavioral health system of care.

I think that is it. I know that we will be sending the presentation around.

I don't know exactly, Dr. Hoffman --

DR. HOFFMAN: I was just going to say, since we've got so many questions today and Amy, mark this draft before we send it back out, because it is still a draft, a working draft.

Erin, I think it might be better -- I started just to say to send us the questions, but I want to make sure that we keep them all together for the TAC. Do you think it would be better if we just have folks send you the questions?

Or Dr. Schuster, could you compile the questions or suggestions on the PowerPoint and send them to us later?

DR. SCHUSTER: Yes. I think we can do that.

DR. HOFFMAN: I think it might be better.

DR. SCHUSTER: I think we have made some notes here and we have a

mechanism for people to send those questions.

MS. CARON-FRANKEL: I wanted to say Dr. Schuster, we did have someone from our team -- I should have mentioned it. We did have someone from our team on the line that was taking detailed notes on the questions as well.

DR. SCHUSTER: Good.

MS. CARON-FRANKEL: But send anything that you have as well. I should have mentioned it. Thank you.

DR. SCHUSTER: That's good. It would be helpful to have this PowerPoint as a reminder to us about what questions we had.

DR. HOFFMAN: We will send it out.

DR. SCHUSTER: Mark it draft. I would suggest you put the time frame on the PowerPoint, the time frame for the study.

DR. HOFFMAN: Amy, we will consider this number one, and then we will have a revised, to just keep it straight,

because folks will get all confused if we end up with three or four of them.

DR. SCHUSTER: Let's call it Version 1.

MR. SHANNON: Should we put the date on it as well?

DR. SCHUSTER: It actually has the date, I think -- the first slide, it has the date on it.

Yeah. You know, this is a great start and I think any time that we are faced with data, it raises tons of questions, and I think you got some good ones and you had some, you know, some good precipitators of the questions, so we appreciate that.

And I think we want to -- I think we're all dedicated to really getting a good feel in trying to figure out what the variables are, and it is tremendously complex.

So I appreciate the presentation, I think it was a good idea to do it. I appreciate your hanging in there with us, Amy. And Bart, as well, to

try to answer these questions.

You know, this little BH TAC did a Medicaid study on the issue of targeted case management, and I think those of us on that little work group working with the DMS staff and then with the UK staff, realize the complexity of looking at Medicaid data and trying to ask the right questions, and get the right answers, and get the right data in the right place, and so forth. And that was a tiny piece compared to what you're offering here. So I think you have some idea about what our questions are, but we do appreciate that. And we will follow up with you.

MS. CARON-FRANKEL: All right. Thank you all. Thank you, Dr. Schuster. Thank you for your questions. Much appreciated.

MR. SHANNON: Good work, Amy. Thank you.

MS. CARON-FRANKEL: Thank you. Good to see you.

DR. SCHUSTER: And thank you, Leslie, for bringing that forward.

I have an item on the agenda about following up on the audits, but we really kind of talked about that around the response to the recommendations, and also we are looking at, you know, what is the track going forward on looking at prior authorizations.

And I think Jennifer Dudzinksi was on but had to leave, and she is our resident guru on audits and so forth, so I am going to move on and we will come back to that next meeting.

Our favorite thing, Leslie, and of course, I am nervous as hell, because I don't think CMS signed off on our 1915(i) SPA, right?

DR. HOFFMAN: Yeah, well we did I think Ann is on. She is going to give you an update as well, but we did get it submitted back to them the day before Friday.

MS. HOLLEN: Friday. January 17th we officially submitted and put it back on the clock, so as of today, we don't have official CMS approval, and our

timeline is really contingent on that approval.

I want to say that the implementation dates still remains 7/1/25, which is what we have in the application to CMS. Our goal is to begin training and onboarding providers two to three months in advance of the go live date of RISE.

Of course, system changes for provider enrollment, billing, integration of the functional assessment tool, and key factors associated with implementation are all built into that.

I do want to finally say that regulations are drafted and under internal review and DMS anticipates following up with LRC in February, and I'll open the floor up to my colleagues in Medicaid if they want to add anything to the conversation.

DR. HOFFMAN: I would just also say that, internally, we are working on a lot of things in the background, of course. There are tons of system changes and contracts and regulations and all

those kinds of things that are going on in the background that folks forget about sometime, so we are working diligently to get this going.

We do support -- Ann and I both in the two departments support this state plan amendment to get approved and we are trying to work as quickly as we can.

DR. SCHUSTER: With things in a bit of an uproar in DC, we really don't know. I guess there will be some massive changes.

I understand that HHS, all of their travel has been removed and I don't know what all is going on, so I'm sure that we will have to wait and see.

MS. HOLLEN: We are still working. We are not sitting on our hands. We are working as if we are getting approval, so we continue to have regular meetings, Myers & Stauffer is also helping to keep us on track, so we are still working on it.

DR. SCHUSTER: Good.

DR. HOFFMAN: I would mention,

too, that we got acknowledgment that they did receive our application back but if we don't hear from them in a couple of days, I told Jodi to give them until at least Friday, because we sent it on a Friday and Monday was a holiday, so I told them to give it until Friday because, like you said, Dr. Schuster, it is probably a crazy place, right, to get your work done there.

DR. SCHUSTER: That would be great. All right. Well, thank you very much. I'm glad that you are still -- we need this badly, as you know, so we are going to keep on keeping on, as they say.

Is there any status update on the reentry waiver?

DR. HOFFMAN: I was just going to give you a couple updates, Dr. Schuster, and I don't want to take too much more time, and you might know some of this already.

But you are aware that we submitted our monitoring plan on November the 26th. We had a public forum that we conducted December the 12th, so if anybody

wonders if that is on the website, we are hoping to have that posted probably sooner than later, but before the next Behavioral Health TAC.

The reinvestment plan and evaluation design that was submitted on time. Everything we have done has been on the day or a day or two earlier. We try to get those in.

Documents submitted to CMS are not typically published until we get back-and-forth with our back-and-forth conversations completed with CMS in case they want us to change anything.

With January 1 starting, our whole escalation and focus has been on our implementation plan for the first of 2025, as you might be aware, our Kentucky implementation go live of the Consolidated Appropriations Act. I think that we are the first state that did this.

We went live on January 1. It doesn't meet all of the requirements for the reentry piece or the full acknowledgment of the Consolidated

Appropriations Act, so we are still working with those things so that the CAA will align more with the 1115 efforts in 2025, and some efforts in the last quarter of 2024 was starting to advance that.

So we are very far ahead of the state, other states. I haven't heard from any different. I was told by CMS that we were the first state to send in the state plan amendment for the Consolidated Appropriations Act.

And I know a lot of that just sounds like fluff, but if you can imagine all of this or that we have going on, we are ahead of the game on this one, and we are trying very hard.

And we meet with Steve Shannon and the Returning to Society community folks on a regular basis and trying to keep everybody apprised. Very transparent, we want you to know what is going on.

Our dates for the next Acres, which is our Kentucky Advisory and Community Collaboration, I think that's

coming up soon in February.

I would also mention that we are very proud and pleased that in the midst of all of this, we were able to get the Consolidated Appropriations Act grant approved. It's a four-year grant and it's approximately $5 million. Our first year is around $1.6 and we will probably see more information about that later.

It looks like what they are going to do for this grant, not just giving you the full amount or approval for the full amount, they gave us the first year and then each year we will ask for the amount that we had originally asked for plus for any reconciliation from unused funds for the previous year. So it actually could mean that our numbers may move around a tad.

We are very pleased with that. That actually has some embedded funds to assist with our jails. We were just starting to work with our jails as well as giving some funds directly to the Department of Corrections and our sister

agencies -- they are actually outside of our cabinet, but at this point I feel like they are totally our sister agencies -- but giving money to DOJ and DOC for alignment, auditing, making sure they are in compliance and those kinds of things.

More to come on that grant. We really just got the reward just recently. I sent that out for everybody. So more to come.

I think that is all I have for you right now for reentry and CAA. We are busy at work and doing a lot of these processes manually right now for CAA to ensure that we got to have a Kentucky go live of January 1.

DR. SCHUSTER: Yeah. I think you sent the notice out about that grant. I'm really glad to hear that you are starting to talk to the jails --

DR. HOFFMAN: Yes.

DR. SCHUSTER: -- Leslie, because so many of our state prisoners are in those local jails and they vary tremendously. I know that is a much

harder task than dealing with Department of Corrections and having the prisons.

DR. HOFFMAN: Yes, it is.

DR. SCHUSTER: That's very much more contained. So glad to hear that.

DR. HOFFMAN: Angela started last year working with the Jailers Association and we had several meetings with them, and just moving forward with how to best -- because we don't have a lot of experience, we are trying to figure out how to best address those each individual jails and some of them are very rural and all are publicly elected. They are a little bit different in each county.

DR. SCHUSTER: Right. Yeah. Thank you.

Any other questions for Leslie on the 1915(i) or the reentry?

How about the 1915(c) waiting list, Leslie?

DR. HOFFMAN: Home and Community-Based waiver, so that's our HCBS waiver, 2,819. Michelle P. waiver is 9,409, and Supports for Community Living

is 3,531.

DR. SCHUSTER: No waiting list for either of the ABI waivers.

DR. HOFFMAN: No. This report was run, Dr. Schuster, on the 17th. That is the last report that I have.

DR. SCHUSTER: Okay. Thank you. I don't have the numbers in my head from the last time you reported in November. I will have to go back and look. You don't have that?

DR. HOFFMAN: I don't have that right in front of me. They are a little fluid. And actually, if I check it the same day 20 minutes later, it is different.

DR. SCHUSTER: Oh, I am sure that is true. But it continues to hover. Actually, that looks high to me. So that is 3,000, 12,000, 15,000 -- that looks more like 16,000. I think that is high.

DR. HOFFMAN: Waitlists, let me see. Let me just double check. That should be around -- I will double check. I think the last time I reported to you it

was around 13,900.

DR. SCHUSTER: Yeah. That is what I was remembering.

DR. HOFFMAN: I do have that.

MS. CLARK: Leslie, that may be the unduplicated number.

DR. HOFFMAN: Oh, okay.

MS. CLARK: I'm not sure what report --

DR. SCHUSTER: Misty has in there -- duplicated it is 13,992.

DR. HOFFMAN: Thank you, Misty. We have been trying to do better at being transparent to let you all know that we have a lot of folks that are on multiple waitlists, and a high amount of folks who receive services already in one waiver but are on another waiting list, and then a high percentage, of course, that do have eligibility for state plan services if needed.

DR. SCHUSTER: So the unduplicated number, is just counting them one time for a waiver waitlist. They're not on multiple wavered waitlists. It

doesn't take into account any of the already getting other Medicaid services.

DR. HOFFMAN: That's correct.

DR. SCHUSTER: Okay. Thank you.

And do you have a wait time for the PDS services? I'm still hearing from people about them.

DR. HOFFMAN: Dr. Schuster, you can appreciate this -- my back of the napkin math. I'm just teasing. But we tried to pull this together for you. This is rough and don't hold me to it because we have to do -- this is just preliminary and we have to go back and do some deep diving for you, but it looks like for HCBS waiver, it looks like we have about 10 percent at less than three years, 22 percent at less than -- I'm sorry the first one was three years. Did I say that? Twenty-two percent at less than two years and 76 percent at less than one year. And I just did some quick averages a few minutes ago before this call. And then, that is the HCB waiver.

For the Michelle P. waiver, I've

got 26 percent at less than three years, 50 percent less than two years, and 24 percent is less than one year.

And SCL, we just had it was easier to get to. It was eight months or less. Everybody is eight months or less.

So we can do, just let me know how you want that to look and we can do a better deeper dive and break that out more for you going forward.

MS. HASS: Sheila, is the percentage that you said, Dr. Hoffman, what about ABI, because I know that there are people waiting for ABI.

DR. HOFFMAN: Oh, I'm sorry. I've got -- now this is what I've got in my list that was given to me today. ABI, 1 percent less than two years. I think that is what I've got.

Let us do a deeper dive on that one as well. I didn't have much. I had zero on ABI LTC.

MR. SHANNON: Are these people who are getting PDS and their wait time, or people who are waiting who aren't

accessing services yet?

DR. HOFFMAN: Misty, correct me if I'm wrong, these are people that are on the active waiting list.

DR. SCHUSTER: For PDS.

DR. HOFFMAN: Yes. For PDS.

MR. SHANNON: So they are not getting waiver services now?

DR. HOFFMAN: No.

Don't forget folks do have -- and I know you got waiting lists, they do have an option for traditional, but many wait. That is what they are looking for.

DR. SCHUSTER: Yeah. Let's -- I kind of like the less than three years, less than two years. I think what you have given us before is kind of average.

DR. HOFFMAN: Yes. It's hard.

DR. SCHUSTER: And it was hard to understand.

DR. HOFFMAN: It is. I thought just before this call I thought, well, maybe if I can put them into categories, but the best thing that I saw was, of course, large amounts were less than a

year on HCB, and Michelle P. about 25 percent less than a year.

And of course, SCL is already less than a year, so we can average those together into one as well for you.

DR. SCHUSTER: Leslie, what is it a percentage of?

DR. HOFFMAN: The total number that we put on the waitlist that we are aware of.

DR. SCHUSTER: So you have the population of people that are waiting for PDS, and of those, 76 percent have been waiting less than a year.

DR. HOFFMAN: That's correct. And I want to double check those numbers with our sister agency as well.

DR. SCHUSTER: I am just trying to wrap my head around, is that the best way for us to track this.

I think I also want the raw numbers.

DR. HOFFMAN: Okay.

DR. SCHUSTER: How many people is that 2 percent that have been waiting?

DR. HOFFMAN: And again, please don't -- like I said, I did some really quick math there.

DR. SCHUSTER: Right.

DR. HOFFMAN: I might be off, say, a percentage or two. Rounding up.

DR. SCHUSTER: But it gives us a ballpark.

But don't you think, Mary, it would be helpful to have those numbers?

MS. HASS: I was just getting ready to echo saying numbers of people, because you say you don't have a waiting list for ABI, but you have a 1 percent waiting for PDS. So I'm trying to wrap my head around that.

So yes, I think numbers of individuals or number of slots, however way you all want to characterize it, I think the percentages are nice, but I don't think it tells us the whole story.

DR. HOFFMAN: Misty, are you on? Is it one person in ABI? Is it one person is less than two years for PDS?

MS. WRIGHT: Yes, currently on

active waitlists we have one person for ABI only.

DR. HOFFMAN: Okay. It's not 1 percent. I got one person on that one.

MS. HASS: Okay.

DR. SCHUSTER: So let's do both the percentage and the raw number if that's possible.

DR. HOFFMAN: And Misty, if you are on, you can help me with that for the next time?

MS. WRIGHT: Absolutely.

MS. HASS: And do both ABIs, because I'm questioning that one person because just from what I was told about by one of the comp cares -- I'm not saying that's not accurate, maybe that person already got the services and I wasn't aware, but, yeah. I would like to know it broken out for both ABIs.

MS. CLARK: And I would say that the data is only as good as we get, so if somebody is on the list and then they are given PDS, but we are not notified for a long time until we are going back through

checking our list, then it's possible --

DR. SCHUSTER: Yeah. That's a good point, Alicia. Thank you.

MS. CLARK: People don't always follow up with us when --

DR. SCHUSTER: When they get it. So reconciling anecdotal information with the numbers that you actually get, you know, we know that there is some slippage, but it is just a way of keeping track of it because I think Mary is like me. I keep hearing from people about the long waits for PDS and I'm trying to figure out -- it's in Louisville so their ought to be providers there.

DR. HOFFMAN: Dr. Schuster, and I am not sure, but if you are hearing from the Michelle P. waiver folks, that one has a larger percentage that have been waiting longer so I'm just going to mention that.

DR. SCHUSTER: I think it is Michelle P.

DR. HOFFMAN: That's probably what you are hearing.

DR. SCHUSTER: And Michelle P.

is our problem child in terms of just look at the number of people on the waiting list just to get into Michelle P.

DR. HOFFMAN: Yes, it is around 50 percent.

DR. SCHUSTER: And so many of those our kids, right?

DR. HOFFMAN: Yes. And on HCB, about 76 percent are less than a year, but you are probably not hearing from them as much.

DR. SCHUSTER: As much, yeah.

DR. HOFFMAN: And SCL is moving fairly quickly. I know eight months is still a long time but considering where we are, I think that one is moving fairly quickly.

DR. SCHUSTER: Well, thank you. We will keep working on it. We will come up with the back of the napkin as they say, but it is helpful to have those numbers.

And thank you, Misty for your input on those numbers as well.

Any update on the ABI waiver in

terms of access to therapy services?

DR. HOFFMAN: So as of today we are still on hold, and I have mentioned this to you all in other calls, but I will make sure that we have ample notification and communication out to folks, so still on hold right now.

MS. HASS: Dr. Hoffman, is it okay if I go, Sheila?

DR. SCHUSTER: Yes.

MS. HASS: I received a telephone call from a doctor. He is stating to me that he has a new client that is receiving -- or who had just received their allocation for the ABI waiver, and I don't remember if they told me long-term or they told me rehab, but I think they said long term, but that he was told because his client was new, that he would automatically have to go in to the state plan, but if he had been a prior already on the ABI, then he didn't have to go in to the state plan. Is that true?

DR. HOFFMAN: I am looking. There was a communication that came out --

this was two waiver amendments ago -- CMS started asking why were the therapies still in there? We were under the understanding that you removed them.

And there was some communication, I had a copy of it, but there was two communications, I believe, I'm lying. One. One communication, I think, that came out while Pam was still here, that said if it is a new member who never received services in the past, that they would go through state plan, but if it is an existing member, then we are on hold.

Alicia, am I correct? I am looking for that letter right now.

MS. CLARK: Yes. You are correct.

DR. HOFFMAN: Thank you. So that is probably what is going on, Mary.

Alicia, do you have a time frame? Was it May or April? I think it was April.

MS. CLARK: To be honest, I don't know. I can try to go over --

DR. HOFFMAN: I think it is April and I have it here somewhere and I will try to find it again.

MS. HASS: I directed the doctor to you guys, but he is very -- these are his words -- he is very depressed. He has somebody who is newly injured and would benefit from the therapies, but is not able. And again, these are his words, not mine.

And I did direct him to you and to Lisa Lee, but I think there is just a lot of -- I don't know how to say it. There is a lot of pessimism around the ABI waiver and the therapies.

It is great that you are still keeping those ones in there, but for newly injured folks, it is really kind of arbitrary because they are not able to access the more skilled therapies that you would get from some of the other individuals.

So anyway, that is just a keynote, those are his words. I did direct him to you and to, Commissioner

Lee, but just to say there is still a lot of pessimism around the therapies.

DR. HOFFMAN: Okay. And Mary, I know you don't want to hear this, but if the individual needs this service through the state plan and they can show medical necessity, they should be able to continue services. I know that is not helping you with the situation of a specific ABI provider, unless that ABI provider also has, you know, a straight Medicaid number which they can bill, which a lot of our providers do. A large percentage, I think, do have those numbers. I know there is some happiness related to rates and things like that.

MS. HASS: I have asked him to write something up and I am hoping that he will, but he is a doctor and he has served our clientele for many, many years, so I am hoping that he will put something in writing to me and I will then forward it to you if he has not already contacted you.

DR. HOFFMAN: That's fine.

Thank you.

DR. SCHUSTER: All right. Thank you Mary and Leslie.

Next is the survey results from the survey that was sent out about changes to the MAC and the BAC.

And the deadline was December 31st, I think. Is anybody on from Medicaid that can respond to this?

MS. BICKERS: I believe Veronica is still working on constructing answers from all of the feedback.

From my understanding, I believe we got a lot of feedback that they are working on getting compiled into one response-type document.

DR. SCHUSTER: Okay. She sent me a note telling me that Commissioner Lee was on vacation and Leslie would be covering for Jiordan today, but she did not mention the survey.

DR. HOFFMAN: I don't have any additional information for you on the survey, Dr. Schuster, but we can follow up on that.

DR. SCHUSTER: Well, it is on the MAC agenda too, and that is tomorrow so it would be helpful to, you know, she told me in the note to me that they are not prepared to talk about the legislation itself because it still is not completed and it is still under wraps, but I thought we would at least get some feedback on the survey. So if you might ask her for that.

DR. HOFFMAN: I will ask Veronica, if Veronica plans to.

DR. SCHUSTER: Thank you.

Are there any recommendations to the MAC from the TAC?

I think that we are not ready to make a response to the DMS response to our last recommendation, so I don't think that we have anything there.

Anybody else have anything?

MR. SHANNON: I don't think so.

DR. SCHUSTER: Okay. Any other voting numbers have any recommendations they want to put out?

MS. HASS: Not at this very moment.

DR. SCHUSTER: Okay. All right.

In the March meeting, we will go back to the issue about approvals of residential SUD treatment services.

I think that we did not settle -- is this right, Erin? We talked in November about what we would ask the MCOs to report on, but I don't think we ever actually finalized it.

MS. BICKERS: That was for the MAC.

DR. SCHUSTER: No. That was the TAC here.

MS. BICKERS: Closing of the care gaps? That was on the MAC agenda.

DR. SCHUSTER: No. This is about the approvals of the SUD residential treatment services.

MS. BICKERS: No. My apologies. No. I don't believe we made that formal request in the last meeting.

DR. SCHUSTER: All right. So I will get back to Bart, and Mandy had brought that issue forward and we had had a discussion. I will have to look at the

minutes from the November meeting and we will get that out.

I did have a new business item that came from Dr. Rayapati who would like to have a discussion of the 8-unit cap on peer support specialty services. That is H0038. He says given the overwhelming data showing the benefit of peer support services, do the MCOs have any guidance on how to continue providing them with this 8-unit cap?

I think what we will do is to circulate that as an agenda item in March and ask the MCOs to be prepared to respond to that.

Can you make a note of that also, Erin?

MS. BICKERS: Yes, will do.

DR. SCHUSTER: All right. Thank you.

Any formulary issues? That is the other thing that we always put under old business.

What was that code again? It was H0038, which I think is the code for

peer support specialty services.

And I don't know how recent or whatever that 8-unit cap is.

Do you know Steve? Do you remember?

MR. SHANNON: I do not.

CHRIS: It was capped as of January 1st. The old cap was 20 units.

DR. SCHUSTER: Oh, okay. So it is a decrease from 20 units to 8 units is the cap?

MR. BALDWIN: It was in a provider letter. I'm trying to find it so I can send it to you.

DR. SCHUSTER: Okay.

CHRIS: It also reduced the maximum lifetime cap per client to 200 units.

MR. SHANNON: Right. I remember that.

CHRIS: Not sure if there was a cap on that before. But essentially, five weeks of treatment is all that is approved now.

DR. SCHUSTER: Wow. Okay.

MR. BALDWIN: That would be a great issue for our next meeting because I believe those are arbitrary caps that are not necessarily tied to assessment and treatment.

MR. SHANNON: Right.

DR. SCHUSTER: Yeah, I'm sorry. Who is Chris that gave us that information?

CHRIS: I'm with Oliver Winston with Dr. Rayapati's office.

DR. SCHUSTER: Okay. Thank you, Chris.

MR. BALDWIN: And that was Bart chiming in on the provider letter, Sheila.

DR. SCHUSTER: Yes. I know. You come up with your full name. But I didn't know who Chris was.

MR. BALDWIN: Okay. Gotcha.

DR. SCHUSTER: I didn't know if he was an interloper from outer space or what. He seemed very knowledgeable.

I'm glad that you gave us that information, Chris.

DR. PATEL: Madame Speaker, can

I ask a question?

DR. SCHUSTER: Yes.

DR. PATEL: This is Chirag Patel from WellCare. We represent the MCO. We would love to give a retort and a response.

Part of our response, can we bring the evidence-based guidelines related to or not existing for these particular services so that we can have a discussion rooted in science and evidence? Because there are some bodies of literature out there discussing that. Maybe we could use that as grounding information so we are all working from the same set of understanding around those particular services.

Because while it does feel like a huge delta between 20 and 8, there was a reason why DMS did that and we would like to articulate maybe some of the rationale why we supported that.

DR. SCHUSTER: We are always happy to see real data and science, Dr. Patel, and if you would like to send

me any of that in advance, I'm happy to circulate that so people have a chance to dive into it.

DR. PATEL: Yeah, my team and I will confer, but we will make sure that we involve the other MCOs as equal stakeholders in that discussion in that response. Thank you so much.

MR. SHANNON: I agree, Sheila, getting it beforehand would really help.

DR. SCHUSTER: Yeah, because otherwise, everybody is really hearing this, kind of like the presentation that we had on the, you know, needs assessment, and then everybody is kind of trying to take in the information.

But if you have data, Dr. Patel, and a rationale, then let's see it. Send it to us in advance.

DR. PATEL: Thank you.

DR. SCHUSTER: Thank you.

Any formulary issues?

Val, I usually count on you.

Kathy Dobbins is asking, "Went from 20 to 8 units with what frequency?"

CHRIS: Per day.

DR. SCHUSTER: Per day. Okay.

Per day, Kathy.

MS. DOBBINS: Thank you. I've got a cold or bronchitis or something so I'm off-camera.

DR. SCHUSTER: Okay. Thank you.

Val, anything that you are hearing from consumers?

MS. MUDD: No.

DR. SCHUSTER: All right. Our next MAC meeting is tomorrow, so get up bright and early at 9:30 Eastern time and come to the MAC meeting.

MR. MARTIN: Sheila?

DR. SCHUSTER: Yes.

MR. MARTIN: This is Barry. I think Darren was on here. We were going to talk about the IOP issue again.

DR. SCHUSTER: Oh, okay.

MR. MARTIN: That still has not been resolved. I am not sure where we need to take this from.

MR. BIBB: Our ask is that the state open the regulation up for

discussion because a retroactive perspective or interpretation of this has resulted in just mass recoupments without providers ability to go back and rebuild claims due to timely filing.

MS. EISNER: And just to add on to the PHP IOP, we are still waiting on guidance from DMS on the use of Telehealth for IOP and PHP.

This is Nina Eisner.

DR. SCHUSTER: I see you, Nina.

MR. MARTIN: I should have included you, Nina, as well. Darren and Nina.

MS. EISNER: That's okay.

DR. SCHUSTER: Tell me again about the Telehealth issue.

MS. EISNER: We are still trying to get resolution from an October of '23 statement from DMS that Telehealth was no longer an option for IOP PHP.

We did get a follow up from the Commissioner -- I don't have the dates in front of me -- but back in the winter that CMS was going to allow Telehealth for PHP

IOP as long as medical necessity criteria were met and appropriately clinically provided, but providers across the spectrum of care have been reluctant to re-implement that until we have a provider notice that overrides the communication from October of '23. So we are still waiting on that.

DR. SCHUSTER: And you have raised that the MAC meeting, Nina, right?

MS. EISNER: I have. MAC, TAC --

DR. SCHUSTER: I was trying to remember because I that we had a discussion about it and I thought there was some resolution, no?

MS. EISNER: No. A couple of the hospital providers and KJ have drafted a draft provider notice and given it to DMS just based on the communication that we had received, so we thought it would be a slam dunk, but we are still waiting.

MS. SPARROW: Hi, Nina. This is Angela Sparrow.

MS. EISNER: Hi, Angela.

MS. SPARROW: A provider letter has been drafted and it is under review, so there is a draft and we will take it back as a follow-up and resolution.

MS. EISNER: Thank you, Angela. I'm going to ask the same question in the MAC just FYI.

MS. SPARROW: Okay. All right. We will be prepared with an update.

DR. SCHUSTER: I knew that we had had this discussion before at the MAC --

MS. EISNER: Yes, thank you so much.

DR. SCHUSTER: -- so we need to be sure that that gets resolved.

We have the IOP billing issue that Mary and Darren and Nina, you were helping them with that.

The next issue. It has to do with the calendar and counting the days?

MS. EISNER: There must be at least three days of service delivered within a rolling seven days -- calendar days -- otherwise none of the care is paid

for.

MR. BIBB: And monies have been recouped from years ago without the ability to go back and bill those services as individual services.

MS. EISNER: There are some hospitals that are experiencing retro recoupments back to 2022.

MR. BIBB: And we just want some open discussion about it.

MS. EISNER: Yes, please.

MR. BIBB: Yes, please.

MS. EISNER: Thanks, Darren.

MR. SHANNON: Darren, who is recouping? Medicaid or the MCOs?

MR. BIBB: The MCOs.

MS. EISNER: The MCOs.

MR. BIBB: And then we can't bill -- we don't have no course to bill anything.

MR. SHANNON: Right.

MR. BIBB: The services rendered were not -- okay, I am going to stop. Just please put it on the agenda for next time.

MS. EISNER: Correct. Thank you.

MR. SHANNON: I will finish it for you, Darren. The services rendered were in compliance with the existing regulation.

MR. BIBB: Unless you reinterpret the regulation years later.

MR. SHANNON: Right. Exactly.

MS. EISNER: Yeah.

DR. SCHUSTER: Gotcha.

MR. BIBB: It is a per diem service, by the way, not a weekly service. It is a per diem payment.

MS. EISNER: Correct.

DR. SCHUSTER: Yeah. I remember when you all first brought that up and I thought how does that make any sense? You do the service -- the service is provided, the service should be paid for, because the patient received it. Okay.

MR. BALDWIN: Just to chime in on this, I have heard from providers non-hospital because I know the folks talking about it are hospital, but I have

heard from other folks, just IOP providers with some of the same issues, beyond just hospital providers.

DR. SCHUSTER: Yes. Okay. So we've got a growing --

MR. MARTIN: I guess that's what Darren and I were talking about.

DR. SCHUSTER: -- list. I'm going to have to go on to a second page on the agenda, folks. This is a bad idea.

MR. BALDWIN: Sorry, Darren.

DR. SCHUSTER: All right. Thank you all.

This has been a lively discussion considering that this was a rescheduled meeting, and I appreciate you all and your participation with the rescheduled meeting.

We will see some of you at least at the MAC meeting tomorrow. And stay warm, and otherwise, we will see you in March. Thank you all very much.

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C E R T I F I C A T E

I, STEFANIE SWEET, Certified Verbatim Reporter and Registered CART Provider - Master, hereby certify that the foregoing record represents the original record of the Technical Advisory Committee meeting; the record is an accurate and complete recording of the proceeding; and a transcript of this record has been produced and delivered to the Department of Medicaid Services.

Dated this 31st day of January, 2025.

/s/ Stefanie L. Sweet

Stefanie L. Sweet, CVR, RCP-M